The Hilltop Institute

analysis to advance the health of vulnerable populations

Operating Model and Insurance Rules Glossary of Terms

Adverse selection: The tendency of people who have a greater-than-average likelihood of needing to seek healthcare coverage to a greater extent than individuals who have an average or less-than-average likelihood of need.

Carrier: An authorized insurer, a nonprofit health service plan, an HMO, a dental plan organization, or any other entity providing a health insurance plan or health services authorized under the ACA.

Community rating: A rating method that sets premiums for financing medical care according to the health plan's expected costs of providing medical benefits to the community as a whole rather than to any sub-group within the community. Both low-risk and high-risk classes are factored into community rating, which spreads the expected medical care costs across the entire community.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): A range of standardized, evidence-based surveys and related tools, developed by the federal Agency for Healthcare Research and Quality (AHRQ) for assessing patients' health care experiences in areas such as provider communication and access to health care services.

Delivery system: The way in which health care benefits are delivered to insured individuals. Examples include indemnity plans and HMO plans.

Encounter data: Information documenting the delivery of a service to an enrollee.

Essential health benefits: A set of health care service categories that must be covered by certain plans, starting in 2014. The essential health benefits package must cover the following general categories of services: Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance abuse disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care.

The scope of benefits is to be determined by the Secretary of HHS and equal to the scope of benefits under a typical employer-based plan. Nothing shall prevent a qualified health plan from providing benefits in excess of the essential benefits package.

Experience: The historical loss record associated with risks covered by the health plan.

Exclusive Provider Organization (EPO): A type of managed care plan that provides health care services to enrollees exclusively through its provider network (except members may access emergency services out-of-network). Some but not all EPOs require members to select an in-plan primary care provider. An EPO network is typically larger than an HMO network.

Form: Any application, policy, certificate, contract, rider, and endorsement that relates to health insurance.

Gold coverage level: A level of benefits coverage offered by a QHP that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

Healthcare Effectiveness Data and Information Set (HEDIS): A quality measurement tool that measures health plan performance in specifically identified domains of health care services.

Health maintenance organization (HMO): A health benefit plan that requires enrollees to select an in-plan PCP that functions as a "gatekeeper." Enrollees may receive services only from an in-plan specialist and only with a referral from the enrollee's PCP.

Indemnity plan: A health benefit plan that reimburses claims for health care services delivered to an enrollee by providers selected by the insured individual, without limitations based on the provider's "in-plan" or "out-of-plan" status. Indemnity plan premiums typically are higher than premiums for comparable coverage through delivery systems that restrict an enrollee's choice of providers or reimburse claims for services delivered by out-of-plan providers at a lower rate.

Individual (non-group) market: The market for health insurance coverage offered to individuals other than in connection with a group health plan.

Large group market: The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

Medical loss ratio (MLR): The ratio of incurred claims to premiums earned (i.e., the percentage of premium revenues spent on medical care).

Point of service plan (POS): A health benefit plan that requires enrollees to select an in-plan PCP that functions as a "gatekeeper;" generally an enrollee may access services from a specialist only with the PCP's prior authorization.

Preferred provider organization (PPO): A health benefit plan that requires enrollees to select providers from a panel of network providers with which the PPO contracts. Services may be accessed from out-of-network providers, but at greater cost to the enrollee.

Qualified health plans (QHPs): Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Reinsurance: Sharing of risk by insurance companies where part or all of the insurer's risk is assumed by other companies in return for part of the premium paid by the insured.

Riders: Provisions in an insurance policy allowing for amendments to its terms and/or coverage. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.)

Risk adjustment: The statistical adjustment of outcomes measures to account for risk factors that are independent of the quality of care provided and beyond the control of the plan or provider, such as the patient's gender and age, the seriousness of the patient's condition, and any other illnesses the patient might have. Also known as case-mix adjustment.

Risk corridors: A temporary provision in the ACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

Self-insured large groups: The large group itself bears the risk if claims exceed premiums collected. Self-insured large groups are not subject to state insurance laws or MIA oversight.

Silver coverage level: A level of benefits coverage offered by a QHP that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

Small group market: Generally a group composed of 2 to 50 members for which health coverage is provided by the group sponsor.

Underwriting: The process of identifying and classifying the degree of risk represented by a proposed insured based on individual characteristics.

Utilization management or review: The process of evaluating medical necessity, appropriateness, and efficiency of health care services delivered to plan enrollees under the terms of a health benefit plan.